

CHAPTER 2

Assessing payment adequacy and updating payments in fee-for-service Medicare

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Chapter summary

The Commission makes payment update recommendations annually for fee-for-service (FFS) Medicare. An update is the amount (usually expressed as a percentage change) by which the base payment for all providers in a prospective payment system is changed relative to the prior year. To determine an update, we first assess the adequacy of Medicare payments for providers in the current year (2012) by considering beneficiaries' access to care, the quality of care, providers' access to capital, and Medicare payments and providers' costs. Next, we assess how those providers' costs are likely to change in the year the update will take effect (the policy year—2013). As part of the process, we examine payment adequacy for the “efficient” provider to the extent possible. Finally, we make a judgment on what, if any, update is needed.

This year, we make update recommendations in 10 FFS sectors: hospital inpatient, hospital outpatient, physician and other health professional, ambulatory surgical center, outpatient dialysis, skilled nursing facility, home health care, inpatient rehabilitation facility, long-term care hospital, and hospice. These update recommendations can significantly change the revenues providers receive from Medicare and help create pressure for broader reforms to address the fundamental problem in FFS payment systems—that providers are paid more when they deliver more services without regard to the quality or value of those additional services. Each year, the Commission

In this chapter

- Are Medicare payments adequate in 2012?
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- How should Medicare payments change in 2013?
- Payment adequacy in context

looks at all available indicators of payment adequacy and reevaluates any prior year assumptions using the most recent data available to make sure its recommendations accurately reflect current conditions. We also consider changes that redistribute payments within a payment system to correct any biases that may result in inequity among providers, make patients with certain conditions financially undesirable, or make particular procedures unusually profitable.

The principle that Medicare should pay the same rate for the same service across sectors is a good guide for the Commission's thinking as it considers changes to Medicare's payment systems. Medicare often pays different amounts for similar services across sectors. Setting the payment rate equal to the rate in the more efficient sector would save money for the Medicare program, reduce cost sharing for beneficiaries, and lessen the incentive to provide services in the higher paid sector. However, putting this principle into practice can be complex because it requires that the definition of the services and the characteristics of the beneficiaries across sectors be sufficiently similar. This year we make a recommendation to equalize payment rates for evaluation and management office visits provided in hospital outpatient departments and physician offices. Our analysis shows that the definition of the service and the characteristics of the patients are sufficiently similar to allow this service to be compared across these two sectors. We are beginning to analyze opportunities for applying this principle to other services and sectors, such as the sectors that provide post-acute care. ■

The goal of Medicare payment policy should be to obtain good value for the program’s expenditures, which means maintaining beneficiaries’ access to high-quality services while encouraging efficient use of resources. Anything less does not serve the interests of the taxpayers and beneficiaries who finance Medicare through their taxes and premiums. Necessary steps toward achieving this goal involve:

- setting the base payment rate (i.e., the payment for services of average complexity) at the right level;
- developing payment adjustments that accurately reflect market, service, and patient cost differences beyond providers’ ability to control; and
- considering the need for annual payment updates and other policy changes.

Our general approach to developing payment policy recommendations attempts to do two things: first, make enough funding available to ensure that payments are adequate to cover the costs of efficient providers; and second, improve payment accuracy among services and providers. Together, these two steps should maintain Medicare beneficiaries’ access to high-quality care while creating financial pressure on providers to make better use of taxpayers’ and beneficiaries’ resources.

In the first step, our goal is to base our judgment of payment adequacy on the performance of efficient providers in a sector, as is required by our charter. Efficient providers use fewer inputs to produce quality outputs. Efficiency could be increased by using the same inputs to produce a higher quality output or by using fewer inputs to produce the same quality output. We are exploring ways to approximate the characteristics of efficient providers. For example, we continue to examine the financial performance of hospitals with consistently low risk-adjusted costs per discharge, mortality, and readmissions (Medicare Payment Advisory Commission 2010, Medicare Payment Advisory Commission 2011). We also continue our analysis of efficient providers in the skilled nursing facility (SNF) sector. We have found that some SNFs have considerably lower costs than others and substantially better quality (Medicare Payment Advisory Commission 2011). We plan to continue to refine our identification of efficient providers in the SNF and hospital sectors and extend our efficient provider analysis to additional sectors, such as inpatient rehabilitation facilities (IRFs) and home health agencies (HHAs). However, for many sectors we are limited by the

available data to assessing the aggregate performance in a sector over both efficient and inefficient providers.

To help determine the appropriate level of aggregate funding for a given payment system in 2013, we first consider whether payments are adequate for providers in 2012. To inform the Commission’s judgment, we examine data on beneficiaries’ access to care, the quality of care, providers’ access to capital, and Medicare payments and providers’ costs for 2012. We then consider how providers’ costs will change in 2013. Taking these factors into account, we then determine how Medicare payments for the sector in aggregate should change in 2013.

Within a given level of funding, we may also consider changes in payment policy that would affect the distribution of payments among providers in a sector. The intent is to change the incentives and thus improve equity among providers or improve access to care for beneficiaries. For example, we have made recommendations to remove biases in the SNF prospective payment system (PPS) that make treating complex patients less financially desirable than treating patients who need therapy.

We compare our recommendations for updates and other policy changes for 2013 with current law to understand the implications for providers, beneficiaries, and the Medicare program. As has been the Commission’s policy in the past, we consider our recommendations each year in light of the most current data and, in general, recommend updates for a single year.

Are Medicare payments adequate in 2012?

The first part of the Commission’s approach to developing payment updates is to assess the adequacy of current Medicare payments. For each sector, we make a judgment by examining information on:

- beneficiaries’ access to care
- the quality of care
- providers’ access to capital
- Medicare payments and providers’ costs for 2012

Some measures focus on beneficiaries (e.g., access to care) and some focus on providers (e.g., the relationship

between payments and costs in 2012). We consider multiple measures because the direct relevance, availability, and quality of each type of information vary among sectors, and no single measure provides all the information needed for the Commission to judge payment adequacy.

Beneficiaries' access to care

Access to care is an important indicator of the willingness of providers to serve Medicare beneficiaries and the adequacy of Medicare payments. For example, poor access could indicate Medicare payments are too low. However, factors unrelated to Medicare's payment policies may also affect access to care. These factors include coverage policy, beneficiaries' preferences, supplemental insurance, and transportation difficulties.

The measures we use to assess beneficiaries' access to care depend on the availability and relevance of information in each sector. We use results from several surveys to assess physicians' willingness to serve beneficiaries and beneficiaries' opinions about their access to physician care. For home health services, we examine data on whether communities are served by providers.

Access: Capacity and supply of providers

Rapid growth in the capacity of providers to furnish care may increase beneficiaries' access and indicate that payments are more than adequate to cover their costs. Changes in technology and practice patterns may also affect providers' capacity. For example, less invasive procedures or lower priced equipment could increase providers' capacity to provide certain services.

Substantial increases in the number of providers may suggest that payments are more than adequate and could raise concerns about the value of the services being furnished. For instance, rapid growth in the number of HHAs suggests that Medicare's payment rates are potentially more than adequate and, because the growth has been accompanied by increased cases of fraud, raises concerns about the definition of the benefit. If Medicare is not the dominant payer for a given provider type, changes in the number of providers may be influenced more by other payers and their demand for services and thus may be difficult to relate to Medicare payments. When facilities close, we try to distinguish between closures that have serious implications for access to care in a community and those that may have resulted from excess capacity.

Access: Volume of services

The volume of services can be an indirect indicator of beneficiary access to services. An increase in volume shows that beneficiaries are receiving more services and thus must at least be able to access those services—although it does not necessarily demonstrate that the services are appropriate. Volume is also an indicator of payment adequacy; an increase in volume beyond that expected for an increase in the number of beneficiaries could suggest that Medicare's payment rates are too high. Very rapid increases in the volume of a service might even raise questions about program integrity or whether the definition of the corresponding benefit is too vague. Reductions in the volume of services, on the other hand, may indicate that revenues are inadequate for providers to continue operating or to provide the same level of services. Finally, rapid changes in the volume of services between sectors whose services can be substituted for one another may indicate distortions in payment and raise questions about provider equity. For example, there has been a recent increase in the volume of evaluation and management office visits in the hospital outpatient sector; some of those services may previously have been provided in physicians' offices.

However, changes in the volume of services are often difficult to interpret because increases and decreases could be explained by other factors such as population changes, changes in disease prevalence among beneficiaries, technology, practice patterns, and beneficiaries' preferences. For example, the number of Medicare beneficiaries in the traditional fee-for-service (FFS) program decreased in recent years as more beneficiaries chose plans in the Medicare Advantage program; therefore, we look at the volume of services per FFS beneficiary as well as the total volume of services. Explicit decisions about service coverage can also influence volume. For example, in 2008 CMS substantially increased the number of surgical procedures covered under the ambulatory surgical center payment system. As a result, the volume of services per FFS beneficiary for those services grew rapidly over the next several years. Changes in the volume of physician services must be interpreted particularly cautiously. Evidence suggests that for services for which use is discretionary, volume may go up when payment rates go down—the so-called volume offset. For other services, such as those requiring significant investment in equipment, volume may contract. Whether a volume offset phenomenon exists in other sectors depends on how discretionary the services are

and on the ability of providers to influence beneficiaries' demand for them.

Quality of care

The relationship between quality and Medicare payment adequacy is not direct. Simply increasing payments through an update for all providers in a sector regardless of their individual quality is unlikely to solve quality problems, because historically there has been little or no incentive in Medicare payment systems for providers to spend additional resources on improving quality. Medicare's payment systems are not generally based on quality; payment is usually the same regardless of the quality of care. In fact, undesirable outcomes (e.g., unnecessary complications) may result in additional payments, and sectors with more than adequate payments may have little incentive to improve quality. The Commission has recommended for the past several years that a fundamental change is needed to create incentives in Medicare FFS payment systems to reward better quality, and the program recently has begun to implement several quality-based payment policies.

Providers' access to capital

Access to capital is necessary for providers to maintain and modernize their facilities and capabilities for patient care. Widespread inability to access capital throughout a sector may in part reflect on the adequacy of Medicare payments (or, in some cases, even on the expectation of changes in the adequacy of Medicare payments). Some sectors, such as hospitals, require large capital investments and access to capital can be a useful indicator. In other sectors, such as home health care, there is little need for large capital investments and access to capital is a more limited indicator. In some cases, a broader measure, such as employment, may be a useful indicator of financial health within a sector. Similarly, in sectors where providers derive most of their payments from other payers or other lines of business or when conditions in the credit markets are extreme, access to capital may be a limited indicator of the adequacy of Medicare payments.

The past few years have seen dramatic changes in financial markets. In late 2008, because of the extraordinary conditions in the credit market, access to capital was driven almost entirely by factors other than Medicare payment adequacy and markets essentially froze. In 2009, liquidity began to return and now credit markets appear to have returned to more normal conditions under

which access to capital depends on borrowers' individual circumstances and creditworthiness.

Medicare payments and providers' costs for 2012

For most payment sectors, we estimate Medicare payments and providers' costs for 2012 to inform our update recommendations for 2013.

For providers that submit cost reports to CMS—acute care hospitals, SNFs, HHAs, outpatient dialysis facilities, IRFs, long-term care hospitals, and hospices—we estimate total Medicare-allowable costs and assess the relationship between Medicare's payments and those costs. We typically express the relationship between payments and costs as a payment margin, which is calculated as aggregate Medicare payments for a sector less costs, divided by payments. By this measure, if costs increase faster than payments, margins will decrease.

In general, to estimate payments, we first apply the annual payment updates specified in law for 2011 and 2012 to our base data (2010 for most sectors). We then model the effects of other policy changes that will affect the level of payments in 2012. To estimate 2012 costs, we consider the rate of input price inflation and, as appropriate, we adjust for changes in the product, such as fewer visits in an episode of home health care, and trends in key indicators, such as historic cost growth and the distribution of cost growth among providers.

Using margins

In most cases, we assess Medicare margins for the services furnished in a single sector and covered by a specific payment system (e.g., SNF or home health services). However, in the case of hospitals, which often provide services that are paid for by multiple Medicare payment systems, our measures of payments and costs for an individual sector could become distorted because of the allocation of overhead costs or complementarities of services. (For example, having a hospital-based SNF or IRF may allow a hospital to achieve shorter lengths of stay in its acute care units, thereby decreasing costs and increasing inpatient margins.) For hospitals, we assess the adequacy of payments for the whole range of Medicare services they furnish—inpatient and outpatient (which together account for more than 90 percent of Medicare payments to hospitals), SNF, home health, psychiatric, and rehabilitation services—and compute an overall Medicare hospital margin encompassing costs and payments for

all the sectors. The hospital update recommendation in Chapter 3, however, applies only to hospital inpatient and outpatient payments; the payments for other distinct units of the hospital, such as SNFs, are governed by payment rates for those payment systems.

Total margins—which include payments from all payers as well as revenue from nonpatient sources—do not play a direct role in the Commission’s update deliberations. The adequacy of Medicare payments is assessed relative to the costs of treating Medicare beneficiaries, and the Commission’s recommendations address a sector’s Medicare payments, not total payments. We calculate a sector’s Medicare margin to determine whether total Medicare payments cover average providers’ costs and to inform our judgment about payment adequacy. There will always be a distribution of margins about the average and our intent is not to ensure that every provider has a positive margin. To assess whether changes are needed in the distribution of payments, we calculate Medicare margins for certain subgroups of providers with unique roles in the health care system. For example, because location and teaching status enter into the payment formula, we calculate Medicare margins based on where hospitals are located (in urban or rural areas) and their teaching status (major teaching, other teaching, or nonteaching).

Multiple factors can contribute to changes in the Medicare margin, including changes in the efficiency of providers, changes in coding that may change the case-mix adjustment of the payment unit, and other changes in the product (e.g., reduced lengths of stay at inpatient hospitals). Information about the extent to which these factors have contributed to margin changes may help in deciding how much to change payments.

In sectors where the data are available, the Commission makes a judgment when assessing the adequacy of payments relative to costs. No single standard governs this relationship for all sectors, and margins are only one indicator for determining payment adequacy. Moreover, although payments can be known with some accuracy, there may be no “true” value for reported costs, which reflect accounting choices made by providers (such as allocations of costs to different services) and the relation of service volume to capacity in a given year. Further, even if costs are accurately reported, Medicare as a prudent payer may choose not to recognize some of these costs or may exert financial pressure on providers to encourage them to reduce their costs.

Appropriateness of current costs

Our assessment of the relationship between Medicare’s payments and providers’ costs is complicated by providers’ efficiency and response to changes in the payment system, product changes, and cost-reporting accuracy. Measuring the appropriateness of costs is particularly difficult in new payment systems because changes in response to the incentives in the new system are to be expected. For example, the number and types of visits in a home health episode changed significantly after the home health PPS was introduced, although the payments were based on the older, higher level of use and costs. In other systems, coding may change. As an example, the hospital inpatient PPS introduced a patient classification system in 2008 that will result in more accurate payments. However, thus far, it has resulted in higher payments because provider coding changed, making patient complexity appear higher—although the underlying patient complexity was unchanged. Any kind of rapid change in policy, technology, or product can make it difficult to measure costs per unit of comparable product.

To assess whether reported costs reflect the costs of efficient providers, we examine recent trends in the average cost per unit of output, variation in standardized costs and cost growth, and evidence of change in the product being furnished. One issue Medicare faces is the extent to which private payers exert pressure on providers to constrain costs. If private payers do not exert pressure, providers’ costs will increase and, all other things being equal, margins on Medicare patients will decrease. Providers that are under pressure to constrain costs generally have managed to slow their growth in cost more than those that face less pressure (Berenson et al. 2010, Gaskin and Hadley 1997, Medicare Payment Advisory Commission 2005, Robinson 2011). Lack of cost pressure is more common in markets where a few providers dominate and have negotiating leverage over payers.

In contrast, some have suggested that hospital costs, for example, are largely outside the control of hospitals and that hospitals shift costs onto private insurers to offset Medicare losses. This belief argues that costs are immutable and are not influenced by whether the hospital is under financial pressure. We find that costs do vary in response to financial pressure and that low margins on Medicare patients can result from a high cost structure that has developed in reaction to high private-payer rates. (See the hospital chapters in our 2009–2011 March reports for a more complete discussion of the relation between

cost pressure and Medicare margins.) In some sectors, Medicare itself could exert greater pressure on providers to reduce costs.

Variation in cost growth among providers in a sector can give us insight into the range of performance that facilities are capable of achieving. For example, if some providers in a given sector have more rapid growth in cost than others, we might question whether those increases are appropriate.

Changes in product can significantly affect unit costs. Returning to the example of home health services, substantial reductions in the number of visits in home health episodes would be expected to reduce the growth in costs per episode. If costs per episode instead increased while the number of visits decreased, one would question the appropriateness of the cost growth.

In sum, Medicare payment policy should not be designed simply to accommodate whatever level of cost growth a sector demonstrates. Cost growth can oscillate from year to year depending on economic conditions, relative market power, and other factors. Policymakers should accommodate cost growth in payment policy only after taking into account a broad set of payment adequacy indicators, including the current level of Medicare payments.

What cost changes are expected in 2013?

The second part of the Commission's approach to developing payment update recommendations is to consider anticipated cost changes in the next payment year. This step incorporates not only the uncertainties discussed above concerning what cost growth is appropriate but also the uncertainty of any projection into the future. For each sector, we review evidence about the factors that are expected to affect providers' costs. One factor is the change in input prices, as measured by the applicable CMS price index. For facility providers, we start with the forecasted increase in an industry-specific index of national input prices, called a market basket index. For physician services, we start with a CMS-derived weighted average of price changes for inputs used to provide physician services. Forecasts of these indexes approximate how much providers' costs would change in the coming year if the quality and mix of inputs they use to furnish care remained constant—that is, if there were

no change in efficiency. Other factors may include the trend in actual cost growth, which could be used to inform our estimate if it differs significantly from the projected market basket.

How should Medicare payments change in 2013?

The Commission's judgments about payment adequacy and expected cost changes result in an update recommendation for each payment system. An update is the amount (usually expressed as a percentage change) by which the base payment for all providers in a PPS is changed relative to the prior year. When our recommendations differ from current law, as they often do, the Congress and the Secretary of Health and Human Services would have to take action and change law or regulation to put them into effect. Each year we look at all available indicators of payment adequacy and reevaluate prior year assumptions using the most recent data available. The Commission does not start with any presumption that an update is needed or that any increase in costs should be automatically offset by the update. Instead, an update (which may be positive, zero, or negative) is warranted only if it is supported by the empirical data, in the judgment of the Commission. The Commission takes a year-by-year approach in its deliberations so that the most recent empirical data can be evaluated.

In conjunction with the update recommendations, we may also make recommendations about the distribution of payments among providers. These distributional changes are sometimes, but not always, budget neutral. Our recommendations to shift payment weights from therapy to medically complex SNF cases is one example of a distributional change that will affect providers differentially based on their patients' characteristics.

The Commission, as it makes its update recommendations, may, in some cases, take payment differentials across sectors into consideration and make sure the relative update recommendations for the sectors do not exacerbate existing incentives to choose the sector based on payment considerations. The difficulty of harmonizing payments across sectors to remove inappropriate incentives points out one weakness of FFS payments specific to each provider type and the importance of moving beyond FFS to more global and patient-centric Medicare payment

Harmonizing payments across sectors in post-acute care

More than a third of Medicare beneficiaries discharged from a hospital use skilled nursing or rehabilitation services from post-acute care (PAC) providers. Medicare beneficiaries can seek this care in four PAC sectors: skilled nursing facilities, home health agencies, long-term care hospitals, and inpatient rehabilitation facilities (rehabilitation services can also be provided in a number of ambulatory sectors). There are four obstacles to defining the same service, comparable patients, and the efficient sector in PAC:

- The PAC product is not well defined. Thus, it may not be clear if the services are the same across sectors or if the goal is recovery or preventing further deterioration.
- Patient assessment instruments, needed to adjust payments for patients with different risks and to assess the outcomes of the care they receive, differ among sectors.
- Payments are not accurately calibrated to costs in each sector. The level of payments may be too high in a sector and may also be maldistributed within the sector. The latter problem can result in selection and treatment decisions based on financial rather than clinical considerations.
- A provider may appear to be efficient by discharging patients to another sector, thereby reducing its costs and shifting costs to another provider. This practice may at the same time increase total Medicare program spending.

Several efforts are under way to help overcome these obstacles. CMS is developing a patient assessment instrument that can be used across sectors and will help

define each patient's characteristics and eventually help compare outcomes and quality across sectors. Calibrating payments to costs in each sector may require refining the prospective payment systems. The Commission has recommended rebasing the prospective payment systems and revising the case-mix classification systems for home health agencies and skilled nursing facilities. Better patient assessment at admission and discharge together with more accurate payments will start to help resolve the question of which sector is relatively more efficient. However, the problems of shifting cost to another provider and determining which services are similar will still need to be resolved.

An additional issue is that some patients who require PAC services could receive them in an acute care hospital, reducing the number of care transitions a beneficiary experiences and avoiding a costly stay with a PAC provider. Eventually, payments should be harmonized across both the PAC sector and the acute care hospital sector.

Medicare should seek to ensure that beneficiaries receive the most clinically appropriate and effective care, regardless of the sector. Within the fee-for-service system, if similar services can be delivered in different sectors with no appreciable difference in quality or outcome, payments across sectors should be set at the level of the most efficient sector. Alternatively, this end could be achieved by moving from fee-for-service payments by sector to a more bundled approach that would pay an entity for all necessary PAC services or for those PAC services and the initial inpatient admission. In either case, payments should reflect the characteristics of the patients' care needs, not the sector. ■

systems. As we continue to move Medicare payment systems toward those approaches, we will also continue to look for opportunities to rationalize payments for specific services across sectors to approximate paying the costs of the most efficient sector and lessen financial incentives to prefer one sector over another.

Paying the same for the same service across sectors

A beneficiary can sometimes receive a similar service in different sectors. Depending on which sector the beneficiary chooses, Medicare and the beneficiary pay different amounts. For example, upon leaving the hospital,

patients with joint replacements might go home with home health care or outpatient therapy, to a SNF, or to an IRF, and Medicare payments (and beneficiary cost sharing) can differ widely as a result.

A core principle that guides the Commission's thinking is that Medicare should pay the same amount for the same service, even when it is provided in different sectors. It seems fair for providers in different sectors to be paid the same amount when the same service is provided to similar patients. Putting this principle into practice requires that the definition of services in the sectors be sufficiently similar and that the characteristics of the patients be similar. Where these conditions are not met, offsetting adjustments would have to be made to ensure comparability. Because Medicare's payment systems were developed independently and have had different update trajectories, payments for similar services can vary widely. Those differences create opportunities for Medicare and beneficiary savings, if payments can be set at the level of the more efficient sector. For example, under the current payment systems, a beneficiary can receive the same physician visit service in an outpatient clinic or in a physician's office. In fact, the same physician or other professional could see the same patient and provide the same service, but depending on whether the service is provided in an outpatient clinic or in a physician's office, Medicare's payment and the beneficiary's coinsurance can differ by 80 percent or more. Nevertheless, it can be difficult to find services in different sectors that are defined similarly and to determine whether patients have the same characteristics. The text box on harmonizing payments across sectors in post-acute care outlines some of this complexity.

In this report, the Commission recommends that payments for evaluation and management (E&M) office visits in the outpatient and physician office sectors be made equal. This service is comparable across the two sectors. E&M office visits are defined similarly in both sectors. In addition, because the coding for the service incorporates a specific length of time (e.g., 15 minutes), patient characteristics are accounted for. That is, a more complex patient in either sector would have a longer office visit than a less complex patient. Our recommendation will set payment rates for E&M office visits in both the outpatient department and physician office sectors equal to those in the physician fee schedule, lowering both program spending and beneficiary liability. (See Chapter 3, pp. 74–78, for a detailed discussion of this recommendation.) The Commission will continue to study other services that are provided in multiple sectors to

find additional services for which the principle of the same payment for the same service could be applied.

Budgetary consequences

The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 requires the Commission to consider the budget consequences of our recommendations. We document in this report how spending for each recommendation would compare with expected spending under current law. For each sector, we develop rough estimates of the impact of recommendations relative to the current budget baseline, placing each recommendation into one of several cost-impact categories. In addition, we assess the impacts of our recommendations on beneficiaries and providers. All the recommendations in this report were developed and voted on before the effective date of the sequester provision in the Budget Control Act of 2011 (for a summary of that provision see Chapter 1, p. 19). The sequester provision is scheduled to take effect starting February 1, 2013. If a Medicare sequester does occur, it will change the spending implications of the recommendations. In addition, the report was prepared prior to passage of the The Middle Class Tax Relief and Job Creation Act of 2012; the provisions of this act defer the effect of the sustainable growth rate system and reduce Medicare bad debt payments in certain other sectors (hospitals, skilled nursing facilities, inpatient rehabilitation facilities, and long-term care hospitals). These small changes are not reflected in this report.

Payment adequacy in context

As discussed in Chapter 1, it is essential to look at payment adequacy not only within the context of individual payment systems but also in terms of Medicare as a whole. The Commission is concerned by the long-term trend in Medicare spending per beneficiary—a growth rate that has been well above that of the economy overall—without a commensurate increase in value to the program, such as higher quality of care or improved health status. Growth in spending per beneficiary, combined with aging of the baby boomers, will result in the Medicare program absorbing increasing shares of the gross domestic product and of federal spending. Slowing the increase in Medicare outlays is important. Medicare's rising costs are projected to exhaust the Hospital Insurance trust fund and significantly burden taxpayers.

The financial future of Medicare prompts us to look at payment policy and ask what can be done to develop, implement, and refine payment systems to reward quality and efficient use of resources while improving payment equity.

In many past reports, the Commission has stated that Medicare should institute policies that improve the value of the program to beneficiaries and taxpayers. CMS is beginning to take steps on this road, such as pay for performance, which links payments to the quality of care providers furnish, and collecting and distributing information about how providers' practice styles and use of resources compare with those of their peers. We discuss these steps in more detail in the sector-specific chapters that follow. Ultimately, increasing the value of the Medicare program to beneficiaries and taxpayers requires knowledge about the costs and health outcomes of services. Until more information on the comparative

effectiveness of new and existing health care treatments and technologies is available, patients, providers, and the program will have difficulty determining what constitutes high-quality care and effective use of resources.

As we examine each of the payment systems, we also look for opportunities to develop policies that can create incentives for providing high-quality care efficiently across providers and over time. Some of the current payment systems create strong incentives for increasing volume, and very few of these systems encourage providers to work together toward common goals. New programs such as accountable care organizations may start to address these issues but their impact lies in the future. In the near term, the Commission must continue to closely examine a broad set of indicators, make sure there is consistent pressure on providers to control their costs, and set a demanding standard for determining which providers qualify for a payment update each year. ■

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